

1500

UNITED HEALTHCARE  
P.O. BOX 740800

ATLANTA GA 30374

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

XXX 1

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input checked="" type="checkbox"/> OTHER <input checked="" type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)		1a. INSURED'S I.D. NUMBER 943419663 (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CALICE MELISSA J		3. PATIENT'S BIRTH DATE 12 01 1974 X M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 43 WINTERBERRY COURT		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY COCKEYSVILLE MD		7. INSURED'S ADDRESS (No., Street) SAME	
ZIP CODE 21030		CITY STATE	
TELEPHONE (Include Area Code) ( ) 248-259-7606		ZIP CODE TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. INSURED'S DATE OF BIRTH 12 01 1974 X M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		c. EMPLOYER'S NAME OR SCHOOL NAME Y OF CENTRAL MD	
c. EMPLOYER'S NAME OR SCHOOL NAME		d. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. SIGNATURE ON FILE 07-20-2012 SIGNED DATE			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Pay to Member SIGNED			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) 07 20 2012		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 17a. 1548411564 17b. NPI	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DR. DAVID W. GOODMAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 314 00 ATTN DEFICIT/HY 300 01 PANIC 2. 296 36 MAJOR DEPRESSIO 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 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993. 994. 995. 996. 997. 998. 999. 1000. 1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100. 1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 1115. 1116. 1117. 1118. 1119. 1120. 1121. 1122. 1123. 1124. 1125. 1126. 1127. 1128. 1129. 1130. 1131. 1132. 1133. 1134. 1135. 1136. 1137. 1138. 1139. 1140. 1141. 1142. 1143. 1144. 1145. 1146. 1147. 1148. 1149. 1150. 1151. 1152. 1153. 1154. 1155. 1156. 1157. 1158. 1159. 1160. 1161. 1162. 1163. 1164. 1165. 1166. 1167. 1168. 1169. 1170. 1171. 1172. 1173. 1174. 1175. 1176. 1177. 1178. 1179. 1180. 1181. 1182. 1183. 1184. 1185. 1186. 1187. 1188. 1189. 1190. 1191. 1192. 1193. 1194. 1195. 1196. 1197. 1198. 1199. 1200. 1201. 1202. 1203. 1204. 1205. 1206. 1207. 1208. 1209. 1210. 1211. 1212. 1213. 1214. 1215. 1216. 1217. 1218. 1219. 1220. 1221. 1222. 1223. 1224. 1225. 1226. 1227. 1228. 1229. 1230. 1231. 1232. 1233. 1234. 1235. 1236. 1237. 1238. 1239. 1240. 1241. 1242. 1243. 1244. 1245. 1246. 1247. 1248. 1249. 1250. 1251. 1252. 1253. 1254. 1255. 1256. 1257. 1258. 1259. 1260. 1261. 1262. 1263. 1264. 1265. 1266. 1267. 1268. 1269. 1270. 1271. 1272. 1273. 1274. 1275. 1276. 1277. 1278. 1279. 1280. 1281. 1282. 1283. 1284. 1285. 1286. 1287. 1288. 1289. 1290. 1291. 1292. 1293. 1294. 1295. 1296. 1297. 1298. 1299. 1300. 1301. 1302. 1303. 1304. 1305. 1306. 1307. 1308. 1309. 1310. 1311. 1312. 1313. 1314. 1315. 1316. 1317. 1318. 1319. 1320. 1321. 1322. 1323. 1324. 1325. 1326. 1327. 1328. 1329. 1330. 1331. 1332. 1333. 1334. 1335. 1336. 1337. 1338. 1339. 1340. 1341. 1342. 1343. 1344. 1345. 1346. 1347. 1348. 1349. 1350. 1351. 1352. 1353. 1354. 1355. 1356. 1357. 1358. 1359. 1360. 1361. 1362. 1363. 1364. 1365. 1366. 1367. 1368. 1369. 1370. 1371. 1372. 1373. 1374. 1375. 1376. 1377. 1378. 1379. 1380. 1381. 1382. 1383. 1384. 1385. 1386. 1387. 1388. 1389. 1390. 1391. 1392. 1393. 1394. 1395. 1396. 1397. 1398. 1399. 1400. 1401. 1402. 1403. 1404. 1405. 1406. 1407. 1408. 1409. 1410. 1411. 1412. 1413. 1414. 1415. 1416. 1417. 1418. 1419. 1420. 1421. 1422. 1423. 1424. 1425. 1426. 1427. 1428. 1429. 1430. 1431. 1432. 1433. 1434. 1435. 1436. 1437. 1438. 1439. 1440. 1441. 1442. 1443. 1444. 1445. 1446. 1447. 1448. 1449. 1450. 1451. 1452. 1453. 1454. 1455. 1456. 1457. 1458. 1459. 1460. 1461. 1462. 1463. 1464. 1465. 1466. 1467. 1468. 1469. 1470. 1471. 1472. 1473. 1474. 1475. 1476. 1477. 1478. 1479. 1480. 1481. 1482. 1483. 1484. 1485. 1486.			

**State of Maryland**  
**Uniform Treatment Plan Form**  
 (For Purposes of Treatment Authorization)

Carrier or Appropriate Recipient:  
 Magellan Behavioral Health  
 Fax: 800-365-5030  
 - or -  
 PO Box 4930  
 Columbia, Maryland 21046-4930

PATIENT INFORMATION				PRACTITIONER INFORMATION																											
PATIENT'S FIRST NAME <b>MELISSA</b>		PATIENT'S DATE OF BIRTH <b>12/01/1974</b>		PRACTITIONER ID# or TAX ID <b>52-1982356</b>		PHONE NUMBER <b>410-583-2723</b>																									
MEMBERSHIP NUMBER <b>943419663</b>				PRACTITIONER NAME, ADDRESS & PHONE <b>Suburban Psychiatric Associates, L.L.C. Johns Hopkins at Greenspring Station 10751 Falls Road, Falls Concourse, St 306 Lutherville, Maryland 21093 Phone 410-583-2SAD</b>																											
AUTHORIZATION NUMBER (If Applicable)				Date Patient First Seen For This Episode Of Treatment <b>06/11/2012</b>																											
<p>Have you communicated with the PCP/other relevant health care practitioners about treatment?    <input type="radio"/> Yes    <input checked="" type="radio"/> No</p> <p align="center"><b>DSM-IV MULTIAXIAL DIAGNOSIS (PLEASE COMPLETE ALL FIVE AXES)</b></p> <p>AXIS I      Dx Code    <b>314.00</b>      <b>296.36</b>      Dx Code    <b>360.01</b></p> <p>AXIS II      Dx Code    <b>None</b></p> <p>AXIS III      Does the patient have a current general medical condition that is potentially relevant to the understanding or management of the condition(s) noted in Axis I or II?    <input checked="" type="radio"/> No    <input type="radio"/> Yes</p> <p>AXIS IV      Severity of current psychosocial stressors                         <input type="radio"/> None                      <input type="radio"/> Mild                      <input checked="" type="radio"/> Moderate                      <input type="radio"/> Severe</p> <p>AXIS V: GAF Score    Highest Past Year <b>60</b>                      At first Session <b>60</b>                      Current <b>60</b></p> <p align="center"><b>Current Medications (if not applicable, no response is required)</b></p> <p> <input type="radio"/> Anti-psychotic    <input type="radio"/> Anti-anxiety    <input checked="" type="radio"/> Anti-depressant    <input checked="" type="radio"/> Psycho-stimulant    <input type="radio"/> Injectables  <input type="radio"/> Hypnotic        <input type="radio"/> Non-psychotropic    <input type="radio"/> Mood stabilizer/Anti-convulsant    <input type="radio"/> Other         </p> <p align="center"><b>Symptoms</b></p> <p align="center">Please rate the patient's current status on these symptoms, if applicable. If not applicable, no response is required.</p> <table style="width:100%; border: none;"> <tr> <th></th> <th>Ideation</th> <th>Plan</th> <th>Prior Attempt</th> <th>None</th> <th></th> <th>Present</th> <th>Absent</th> </tr> <tr> <td>Suicidal ideation</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input checked="" type="radio"/></td> <td>Self-injurious behavior</td> <td><input type="radio"/></td> <td><input checked="" type="radio"/></td> </tr> <tr> <td>Homicidal ideation</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input checked="" type="radio"/></td> <td>Substance use problems</td> <td><input type="radio"/></td> <td><input checked="" type="radio"/></td> </tr> </table>									Ideation	Plan	Prior Attempt	None		Present	Absent	Suicidal ideation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Self-injurious behavior	<input type="radio"/>	<input checked="" type="radio"/>	Homicidal ideation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	Substance use problems	<input type="radio"/>	<input checked="" type="radio"/>
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<p align="center"><b>Authorization Request Details</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top;"> CPT Code <b>90805</b>      Number of Units <b>12</b>  Frequency (once a week, etc.): <b>Monthly</b>  Requested Start Date of Authorization: <b>6/19/12</b> </td> <td style="width:50%; vertical-align: top;"> <p align="center"><small>Complete this section only if a second CPT is needed.</small></p> CPT Code <b>  </b>      Number of Units <b>  </b>  Frequency (once a week, etc.): <b>  </b>  Requested Start Date of Authorization: <b>  /  /  </b> </td> </tr> </table> <p>Signature of practitioner:       Date: <b>06/11/2012</b></p> <p>My signature attests that I have a current valid license in the state to provide the requested services.</p>								CPT Code <b>90805</b> Number of Units <b>12</b> Frequency (once a week, etc.): <b>Monthly</b> Requested Start Date of Authorization: <b>6/19/12</b>	<p align="center"><small>Complete this section only if a second CPT is needed.</small></p> CPT Code <b>  </b> Number of Units <b>  </b> Frequency (once a week, etc.): <b>  </b> Requested Start Date of Authorization: <b>  /  /  </b>																						
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SUBURBAN PSYCHIATRIC ASSOC.  
10751 FALLS ROAD #306  
JOHNS HOPKINS AT GREEN SPRING  
LUTHERVILLE, MARYLAND 21093  
(410) 583-2723

Date : 07-20-2012

MELISSA J CALICE  
43 WINTERBERRY COURT  
COCKEYSVILLE, MD 21030

Account Number : 11344  
Referring Phy. :  
Doctor/Provider: DR. DAVID W. GOODMAN

Diagnosis : 314.00  
296.36  
300.01

Date of Service	Place	Type	CPT	Modifiers	Description	Diag	Charge	Units
07-20-2012	11	01	90805		90805-INDIVID TX	123	160.00	1

Check #	Amount	Applied To	Patient
CREDITCARD	\$160.00	07-20-2012	MELISSA J CALICE

Current	Over 30	Over 60	Over 90	Over 120	Statement
0.00	0.00	0.00	0.00	0.00	